Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 02/15/01, 06/07/01, 07/11/01, and 07/30/01?
   b. The request was received on 02/12/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
   a. TWCC-60 and Letter Requesting Dispute Resolution
   b. Provider marked exhibits 1-18
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC-60
   b. EOBs
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 04/23/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 04/25/02. The only response from the insurance carrier was received in the Division on 02/13/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The provider has not received proper reimbursement for services associated with an epidural steroid injection.

2. Respondent: The carrier has reimbursed the provider properly.

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service eligible for review is 02/15/01, 06/07/01, 07/11/01, and 07/30/01.
2. The carrier's EOBs have the denials, "**M** – REDUCED TO FAIR AND REASONABLE", "**D** – REIMBURSEMENT FOR UNILATERAL OR BILATERAL

PROCEDURES IS BEING WITHHELD AS THE MAXIMUM NUMBER OF OCCURENCES FOR A SINGLE DATE OF SERVICE OR MAXIMUM LIFETIME FOR THE CLAIM HAS BEEN EXCEEDED" and "**F** – REIMBURSEMENT IS BEING WITHHELD AS THE PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE BILLED."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
06/07/01 07/11/01	76499-27-22	$350.00 $350.00	$105.60 $105.60	M M	DOP	MFG, GI (I)(A&B) & (III), CPT & modifier descriptors, TWCC Advisory 97-01 Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d)	The CPT descriptor states, "Unlisted diagnostic radiologic procedure." The medical documentation indicates that the provider is billing for fluoroscopic guidance (fluoroscopy). The MFG GI (I)(A) states, "…(TWCC) has incorporated usage of the …(AMA's) 1995 …(CPT) codes". The MFG has CPT code 76000 which has the descriptor "Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg. cardiac fluoroscopy)". The CPT code 76000 is sufficiently descriptive of the procedure performed and the MAR value of 76000-27 is $88.00. The EOBs submitted by the provider showing a higher rate of reimbursement does not meet the criteria of Sec. 413.011(d) of the Texas Labor Code. Therefore, no additional reimbursement is recommended.
06/07/01 07/11/01 07/30/01	76499-27	$300.00 $300.00 $300.00	$0.00 $0.00 $0.00	D D D	DOP	MFG, GI (II)(A&B) & (III), CPT & modifier descriptors, TWCC Advisory 97-01	The TWCC Advisory 97-01 states, "…When videofluoroscopy or fluoroscopy is performed with a myelogram or discogram, **such procedures** (emphasis added) are considered part of the service and should not be billed separately. The procedure in dispute is an epiduragram and is a procedure that should not be reimbursed separately. Therefore, no reimbursement is recommended.
06/07/01	A4649	$15.00	$0.00	F	DOP	MFG, SGR (V)(B)(1)	The referenced SGR states, "Sterile trays (which includes all supplies, gloves, utensils, needles, suture material, etc., needed to perform the procedure). These shall be billed using 99070-ST." This code should not be billed or reimbursed separately. Therefore, no reimbursement is recommended.
06/07/01	A4646	$100.00	$0.00	F	DOP	MFG, SGR (I)(E)(4)(d)	Per the referenced SGR, "additional materials through the same puncture site, reimbursement shall be allowed for the materials only". Based on the SGR the provider would be entitled to reimbursement of additional materials only. The carrier has reimbursed code J1040 as "additional material". The provider is not entitled to reimbursement of the first material. Therefore, no additional reimbursement is recommended.
Totals		$1715.00	$211.20				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 7th day of August 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.